STATE OF KENTUCKY

END-OF-YEAR REPORT

Prepared for

HEW Contract #SRS-500-75-0031

Contract Year 1976-1977

By

Community Health Foundation

Evanston, Illinois

June, 1977

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I. SUMMARY

Community Health Foundation (CHF) prepared this year end report on the State of Kentucky's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program in fulfillment of its obligation under HEW Contract SRS-500-75-0031 for the contract year 1976-1977.

CHF conducted a needs assessment in Kentucky in November 1976 and found a series of interrelated problems with the EPSDT Program:

1. Low screening penetration rate (20%)
2. High incidence of broken screening appointments (50-60%)
3. Wasted efforts by Bureau for Social Services (BSS) caseworkers
4. Inadequate resources (health and transportation) in rural areas
5. Low screening reimbursement
6. Inappropriate screening periodicity schedule.

As a result of the needs assessment, the Department for Human Resources (DHR) and CHF agreed to two technical assistance (TA) areas:

1. Assisting DHR in developing an EPSDT outreach and case management proposal that is eligible for 75 percent federal financial participation (FFP).
2. Assisting DHR in evaluating the appropriateness of Kentucky's screening periodicity schedule by providing a review of periodicity schedules recommended by professional groups.

Thus far, DHR's major planning efforts have been concentrated on developing a funding proposal. While CHF supports DHR's efforts to claim 75 percent FFP for EPSDT outreach, further conceptualization of the program is needed before DHR hires additional staff for this purpose. The revised outreach and case management system should be designed to meet the objectives of: (1) increasing screening penetration, (2) reducing broken screening appointments, and (3) efficiently using workers time; in addition to other objectives for improving the program. Also, the bureaus need to define specifically what activities the additional EPSDT workers will perform.

CHF further recommends that DHR use CHF's working paper, "A Review of Recommended Periodicity Schedules," to determine whether or not Kentucky's annual screening periodicity schedule is appropriate.

CHF also recommends that DHR eventually: (1) assess the impact that transportation resources have on the program and (2) analyze the operating costs of providing screening services to determine an appropriate reimbursement rate.

II. PROGRAM DESCRIPTION

PROGRAM MANAGEMENT

Kentucky's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program was implemented July 1, 1972, with the Department for Human Resources (DHR) designated as the single state agency responsible for the program.

DHR is comprised of five bureaus, three of which share EPSDT responsibilities. These three bureaus are:

1. Bureau for Social Insurance (BSI) -- responsible for administration.

2. Bureau for Social Services (BSS) -- responsible for assisting clients in obtaining EPSDT services.

3. Bureau for Health Services (BHS) -- responsible for developing screening guidelines and overseeing the annual EPSDT plans of local health departments.

The State EPSDT Coordinator works within the Division for Medical Assistance of the Bureau for Social Insurance. EPSDT is her full-time task, with two major responsibilities -- securing EPSDT providers and monitoring the program.

The Bureau for Social Services assigned its EPSDT responsibilities to the Child Care Specialist. She is the counterpart of BSI's coordinator even though she does not spend 100 percent of her time on the EPSDT program.

Because interdependency is necessary between the bureaus operating the EPSDT program, BSI and BSS entered into a formal "Inter-Bureau Agreement" in May 1975. This agreement specifies

the roles for which each bureau has responsibility. The two bureaus are presently in the process of developing a revised agreement.

While BHS did not enter into the agreement, it plays major roles in the program, such as acting as the liaison between DHR and the local health providers and in providing technical assistance to providers requesting it.

Kentucky's program is explained in Guidelines for the Implementation of the K.M.A. P.: Early and Periodic Screening, Diagnosis and Treatment Program, developed by BSI in 1972. It includes such items as the policies, objectives, scope of benefits and use of EPSDT forms. Further, BSI and BSS incorporated EPSDT procedures into their bureau manuals.

The Bureau for Social Insurance conducts on-site reviews for initial certification of screening providers and for continued participation in the program.

An Ad Hoc Advisory Screening Committee of professionals reviews, evaluates and recommends improvements for overall EPSDT program performance. Although physicians and dentists have not been officially requested to actively participate in EPSDT planning, they provide input through program committees and the Medical Assistance Advisory Council. The Bureau for Health Services also has a pediatric consultant available.

DHR's commitment to EPSDT is evidenced by the fact that the Commissioner of the Bureau for Social Services has made EPSDT the bureau's second priority.

IDENTIFICATION OF ELIGIBLES

EPSDT services are offered to those under the age of 21 who have been determined eligible for medical assistance under the categories of AFDC, AFDC-UF, SSI or Medical Assistance (MA). During FY 76 there were 172,676 EPSDT eligibles in Kentucky, with 41,063 residing in Jefferson County, the most densely populated county in the State. Kentucky's two urban counties, Jefferson and Fayette, comprise approximately 30 percent of the State's total EPSDT population.

Approximately 20,248 of the 161,000 (12.5 percent) EPSDT eligibles were screened during FY 75. In FY 76 these numbers increased to 34,876 of 172,676 EPSDT eligibles. (The increase in the EPSDT eligible population is partially due to Kentucky's addition of the unemployed father's category, effective July 1, 1975.)

The county office of the Bureau for Social Insurance determines whether an individual or family is eligible for categorical assistance. Those individuals eligible for categorical assistance under the age of 21 are automatically eligible for EPSDT. The eligibility information is forwarded to the Central Office of BSI to be included in the next monthly print-out of the computerized eligibility list. Cases are also deleted from the eligibility list by the local office sending notification to the Central Office.

Pertinent information on the eligibility list includes the monthly cash grant, if other than medical assistance only;

name or names of the family members included on the case; birth dates of the eligibles; category of assistance; and household address. Action is now underway to expand the eligibility lists to include the client's periodicity schedule. To facilitate outreach, the printed eligibility lists for urban areas are now being sorted by zip code numbers.

Newly approved eligibles receive, by mail, a temporary Medicaid card which verifies their eligibility until such time when the case is entered on the statewide eligibility list. Medicaid cards are then mailed on a monthly basis as long as the case remains eligible. Providers can quickly check whether an individual is eligible for EPSDT by noting the expiration date of the Medicaid card.

NOTIFICATION OF ELIGIBLES

When clients are first determined eligible for assistance by the eligibility worker at the county BSI office, they are given a verbal explanation of the EPSDT program. Shortly after eligibility determination, BSI mails the cash assistance, also enclosing a printed notification of the availability of EPSDT services.

Another printed EPSDT notification will be mailed to the clients (1) in the event their grant status changes; (2) six months after the date of grant determination; and (3) once annually thereafter, during the month of April. A printed brochure explaining the EPSDT program is distributed at local BSI offices and at the screening sites.

If a client is blind, illiterate or does not speak English, either a BSI or a BSS worker will attempt to contact the individual in person to explain the program.

It is proposed that the parents of clients who initially refused to participate in the EPSDT program should be recontacted annually. To add strength to this effort, the interbureau agreement is being revised to require that BSS caseworkers personally contact this group of non-participating clients.

Another proposal being considered concerns clients who have an abnormal screening result and fail to obtain diagnostic and treatment services. The social worker's responsibility here will be to meet with the client's health care provider so that jointly they can devise a plan to convince the reluctant client to obtain these services.

IDENTIFICATION OF RESOURCES

Kentucky's Division for Medical Assistance pursues and approves EPSDT screening vendors. Letters requesting participation in providing EPSDT screening services have been sent to physicians, health departments, schools, Health Maintenance Organizations and Children and Youth Projects.

Almost all local health departments are screening providers and are required to submit an annual county plan to the Bureau for Health Services stating the number of eligibles they are willing to screen that year. The health departments, however, are unable to expand their resources to provide more

time arrives, clients use the lack of transportation as an excuse for not keeping the appointment.

OUTREACH

Outreach is the activity of encouraging clients to use EPSDT services after they have been informed about the program. Although DHR does not have EPSDT workers who devote 100 percent of their time to EPSDT, BSS caseworkers re-explain EPSDT to new clients after they receive a referral from BSI. Also some health departments have used local newspapers and radio announcements for community health education purposes.

Louisville used CETA workers for EPSDT outreach and DHR was pleased with the results. As a result of this project, DHR is preparing a proposal to obtain increased Federal Financial Participation (FFP) funds for hiring EPSDT outreach workers.

DHR staff believe that EPSDT outreach workers could help in reducing the current 60 percent "no-show" rate and increasing the penetration of screenings beyond the current 20 percent level.

Publicizing the EPSDT through public media, an approach which DHR considers attractive, could increase utilization of the services. Some efforts in this direction have already been initiated. The State EPSDT Coordinator has obtained funding to produce an EPSDT slide show and is exploring other financial sources, such as grants for commercial television, radio and other public information material.

SCREENING

The screening process is delineated in Guidelines for the Implementation of the K.M.A.P.: Early and Periodic Screening, Diagnosis and Treatment Program. The core of an EPSDT screening is the nursing assessment, accompanied by nutritional counseling and developmental testing if it is indicated from the medical history and/or from the nursing assessment. The Denver Developmental Test is used in Kentucky.

Approximately 20 percent of the eligibles were screened during FY 76. The most prevalent conditions found were:

5,590 dental problems

2,204 general assessment, including anemia

1,426 vision problems

1,306 hematocrit or hemoglobin

894 hearing

lead poisoning (not available)

Screening services are provided by almost all health departments. In Jefferson County (Louisville), other agencies also provide screening (e.g., the child and youth projects, day care centers, and private physicians). Mobile screening vans are used in two urban areas and one rural area.

All screening providers are reviewed and certified by the Division for Medical Assistance, Bureau for Social Insurance, before they may participate as a screening provider. Each signs an agreement which stipulates that the screening provider is subject to monitoring and evaluation by the Division for

Medical Assistance and, if approved, will be certified as an EPSDT screening provider.

The responsibilities of the screening provider are to provide screening services; to discuss screening results with the client, the parents or guardians; and to arrange appropriate follow-up care for the client.

A health department roster (MAP-F0060 is maintained which indicates the client's progress in keeping the screening appointment, the screening results, whether follow-up referral was required, etc. This roster is sent to the local Bureau for Social Services at the end of each clinic day. When follow-up diagnostic and treatment services are needed, the health department arranges an appointment for the client with an appropriate follow-up provider.

The State's fixed reimbursable rate is $12.00 per screen. The health departments claim this rate is not sufficient to offset actual expenses incurred. Thus, money generated from screening reimbursement cannot be utilized for any expansion of resources. Kentucky's position of providing special tests only to appropriate "high risk" populations may, in part, be due to the low rate established for screening reimbursement. Special tests include blood pressure, VDRL and lead poisoning. Some of these special tests require that the client's blood samples be drawn and given to private laboratories for analysis which charge the health department $5.00 for any laboratory procedure. With the rate of reimbursement for screening services fixed at $12.00, any additional costs, such as the lab

fees, must be absorbed by the screening provider.

Kentucky established an annual screening periodicity schedule based on the State's perception that an annual periodicity schedule was required by the EPSDT Federal guidelines. Neither the medical implications nor practical limitations of having an annual periodicity schedule was examined. From a medical point of view, the most critical stages of child development occur during the first year of life. Having only one screen for the child from birth to age one is inconsistent with the goal of EPSDT for early detection and treatment of handicapping conditions. Furthermore, annual screening of children over the age of eight and repeating certain procedures each screening is neither medically warranted nor cost-effective for the State.

DIAGNOSIS AND TREATMENT

Physicians, in general, are willing to participate in the EPSDT program. In the Louisville urban area, there are more than enough providers of screening, diagnostic and treatment services. Also, in the rural Appalachia area, there is an ample number of providers whose services are made available through a series of special project funds.

This picture of abundant physician supply, however, changes dramatically in rural areas outside of Appalachia. Not only are physicians in short supply, but they also are reluctant to accept a Medicaid patient. The Division for Medical Assistance has been able to combat this problem somewhat

by requesting physicians and dentists to provide services over a broad regional area rather than in just the single county in which they reside.

When the results of a screening test indicate deficiencies or abnormalities, the local health department nurses refer the client to a local provider for diagnosis and treatment. The screening results are recorded on a three-part NCR referral form. Two parts of this form are sent to the provider before the time of the client's appointment. The provider fills out the bottom section of the form, recording the EPSDT services rendered. One copy of the form is returned to the health department. The second copy remains with the child's medical record in the provider's files.

Physicians and other providers bill for EPSDT services using the usual Medicaid claims form. EPSDT services are billed at the "usual and customary rate." Because of this procedure, the Division for Medical Assistance is unable to distinguish between payments reimbursed for EPSDT service claims and those reimbursed for other Medicaid service claims.

Because some providers do not return completed diagnostic and treatment information, necessary information is frequently missing from a child's case record. This lack of information also limits the capability of the Central Office to maintain accurate statistics on the EPSDT program.

CASE MANAGEMENT AND FOLLOW-UP

The EPSDT program is explained to clients during the

grant determination interview and is reinforced by subsequent mailings of EPSDT informational material. In addition, social service workers elaborate on the importance of EPSDT. Clients then make a decision to either request or refuse the EPSDT services. This decision is documented in the client's service record.

BSS workers have the responsibility to aid clients in obtaining EPSDT services if they request support services. This aid consists not only of setting up screening appointments (generally health department clinics) but also assisting in removing all barriers (transportation, day care) that may prevent clients from keeping the scheduled appointments. Appointment reminders are mailed to clients, again informing them of the date and the hour of their appointment.

Health departments, the major screening providers, have the responsibility for performing EPSDT screening services, for counseling clients on the results of the screening, and for arranging diagnostic and treatment appointments.

To ensure that all scheduled clients receive the EPSDT services requested, a roster (MAP-F006) of clients is maintained which lists, per clinic day, those clients scheduled for screening services. The health department records the status of each client, including whether the client kept the screening appointment, results of the screening test, and whether a referral appointment is required. This information is forwarded to the local BSS office so that follow-up procedures can be initiated.

When the client fails to keep an appointment, the BSS

worker is responsible for contacting the person to learn the reason for the missed appointment and to arrange for a second screening appointment if the client requests one. In either case, all pertinent information is documented in the client's service record.

Where normal screening results are found, the case management and follow-up procedures are completed at that point.

The health department and other independent screening providers counsel all clients having abnormal screening results and explain the importance of keeping their appointments with a referral provider. The health department will arrange a referral appointment and contact a BSS worker should the client require any assistance in obtaining or keeping this appointment.

Results of the screening tests are recorded on the three-part NCR client referral form which is sent to the referral provider prior to the client's scheduled appointment time. The referral provider is instructed to complete the bottom portion of the referral form indicating the EPSDT services rendered for the client and to return one copy to the local health department for case management and follow-up procedures. The health department is instructed to wait a "reasonable" length of time for the referral provider to return the form before forwarding the inter-bureau transmittal form (MAP-F007) to the local BSS office. Inter-bureau transmittal forms are also initiated when clients do not keep scheduled diagnostic and treatment appointments. (This happens only in those instances

where referral providers indicate that a client was a "no-show" on the referral form and send it back to the health department.)

The inter-bureau transmittal form also serves as documentation that diagnostic and treatment services were rendered.

Referral follow-up procedures are similar to the screening follow-up procedures.

A significant problem in case management and follow-up procedures stems from the lack of cooperation of referral providers in returning properly completed copies of the referral form to the health department. Unless these forms are returned to the health department, the BSS workers waste considerable time verifying gaps of information on a client's record. It is estimated that 90 percent of all clients keep their appointments for diagnosis and treatment, but less than 10 percent are accounted for via the return of completed assessment forms.

DATA PROCESSING

Several special types of EPSDT reports can be generated from any given data processing system. In addition to the required federal report, other statistical and managerial reports can be produced to monitor, evaluate and improve the overall EPSDT program.

In the State of Kentucky, the required NCSS-120 Federal Report is a computer by-product produced on a monthly basis compiled from several data sources including history files, eligibility files and claim payment files.

For other reports, Kentucky has a special statistical

data processing unit which generates reports concerning no-show data, types and numbers of abnormal conditions discovered during the screening procedures, and the number of clients requiring referrals.

Although few management reports have been generated at the State level, in Louisville print-outs are produced locally which indicate the number of clients screened and referred and the number of clients that do not show for appointments.

It is recommended that a complete EPSDT data processing system contain case finding, tracking and reporting components. The case finding component relates to all aspects of the client's eligibility for assistance, request for EPSDT service and continued eligibility for EPSDT services. The computer center of the Bureau for Social Insurance maintains client eligibility data on data processing files for a two-year period. This information is sent to the State by the counties and placed in the computer which prints out a quarterly listing that is sent to the individual counties.

Certain pertinent case finding elements are not contained on the quarterly print-outs, such as the date of initial request for EPSDT services, nor are the eligibility lists separated by "overdue for service" categories.

The data system does not provide tracking information nor a complete EPSDT report.

Several problem areas can be identified that may pose difficulties in meeting anticipated federal reporting requirements. At the present time, for example, there is no designation

on the current EPSDT encounter form to distinguish an initial screen from a periodic screen, nor is the State producing separate tabulations for initial and periodic screenings.

The computer system is presently unable to indicate the number of eligibles identified through screening for any of the following treatment categories:

1. Those receiving treatment services.
2. Those found not to require treatment services.
3. Those for whom treatment was not available.

The State cannot pick up EPSDT treatment information from the Medicaid claims payment files. The local health department will notify the local BSS department about all clients who missed their scheduled diagnosis and treatment appointments, and BSS will follow-up and schedule another appointment for clients if necessary. Thus, this type of information is not automated and is difficult to compile. In addition, the computer sections of the various bureaus have made no attempt to merge screening and claims payment information together.

The State of Kentucky is able to ensure that only complete screens are tabulated because of the policy of reimbursing only for complete screens.

One final area to consider concerning anticipated federal reporting requirements is in tabulating associated cost figures with EPSDT services. The State can document expenditures for an EPSDT screening service since it is reimbursed at a rate of $12.00. However, it is not possible to extract EPSDT cost information from the Medicaid claims payment files because EPSDT

claims cannot be identified.

From this preliminary assessment of computer capability, it should be mentioned that the State of Kentucky is planning to install an MMIS system in the near future. There are no plans, however, to include an EPSDT module as part of the MMIS package. The State plans to wait until the federal government will offer an EPSDT system to them.

III. PROBLEM ANALYSIS

The many problems hampering Kentucky's delivery of EPSDT services are interrelated, with no single factor identifiable as the key cause for the program's overall weakness.

One complex problem plaguing the EPSDT program is the high rate of broken screening appointments (50-60 percent). Factors contributing to broken screening appointments are:

1. The misconception by some clients that eligibility for income maintenance is dependent upon acceptance of health and social service programs.

2. BSS workers' vague understanding of EPSDT.

3. The low priority that local BSS workers given EPSDT in relation to Title XX services.

4. The difficulty BSS workers have (especially in urban areas) in establishing trusting relationships with clients.

In addition to reducing the number of children screened, broken screening appointments result in (1) wasted efforts by DHR (in helping clients arrange appointments, in obtaining support services and in following up on broken appointments); (2) idle screening resources that were set aside for clients who do not show.

Transportation is another significant problem. There is a lack of transportation resources to take clients long distances for diagnosis and treatment, even though DHR reimburses for this service. Also, BSS workers are overutilized in

transporting clients to screening sites. The BSS manual states that a worker may transport a client only after other means of transportation have been found unfeasible. Some workers are not encouraging the clients to first consider and explore other possible transportation resources.

DHR's low reimbursement rate for screening is another problem. DHR pays $12.00 for a screening while providers claim that a screening costs between $20 and $25 to administer. Some providers are not ordinarily administering some recommended tests, such as lead poisoning, because of the low reimbursement rate. Further, providers claim that the low reimbursement prohibits them from expanding their facilities. Fayette County, for example, has 7,500 EPSDT eligibles but the Fayette County Health Department claims it can provide only 100 screening slots per month.

The shortage of screening resources will be experienced even more intensely if the demand for EPSDT increases while DHR maintains its annual periodicity schedule. DHR incorrectly believed that federal guidelines require annual screenings. Instead, recommended periodicity schedules (by the American Academy of Pediatrics and DHEW) suggest that young children be screened more frequently than annually and that older children and youth be screened less frequently than annually.

Insufficient physician participation for diagnosis and treatment is yet another problem, especially in rural areas. This shortage frequently results because:

1. There are few physicians within the area.

2. Physicians are unable or unwilling to accept any new Medicaid patients.

3. Physicians do not accept Medicaid reimbursement.

The situation is similar for participation by dental providers.

Local health departments and DHR have problems following up on EPSDT services since some participating physicians do not return reports on their diagnostic and treatment dispositions. There is presently little incentive for the providers to share this information; but the diagnosis and treatment information is essential to case management and follow-up.

The EPSDT program is relatively new and has not received adequate publicity to acquaint eligibles with the benefits to be gained. EPSDT's low penetration level may also be partially due to the lack of program publicity and poor health education.

IV. TECHNICAL ASSISTANCE ACTIVITIES

Appendix A contains the proposed technical assistance agreement which outlines the activities to be undertaken, the parties responsible for them and the respective end points for the activities. Because of limited resources, only two technical assistance activities could be selected for this year. Two proposed activities were postponed pending availability of the federal model MMIS/EPSDT module for data processing. Other activities are noted as potential technical assistance activities to be initiated after July 1977.

As a result of CHF's needs assessment and problem analysis and DHR's requests for technical assistance, the two parties agreed that CHF could help DHR most during contract year 1976-1977 by:

1. Reviewing the Bureau for Social Services' draft proposal for 75 percent FFP for EPSDT outreach.
2. Assisting CHR in reviewing the appropriateness of the current periodicity schedule.

CHF staff reviewed the BSS proposal, reviewed all federal regulations pertinent to 75 percent FFP and developed a paper entitled "Summary of Federal Financial Participation Regulations for EPSDT Health Related Support Services" (Appendix B). CHF met with DHR staff to present this paper and offered recommendations for changing the BSS proposal before submitting it to Region IV.

As the second part of the technical assistance agreement, CHF prepared a working paper entitled "A Review of Recommended Periodicity Schedules."

In addition to the two designated areas for technical assistance, CHF provided DHR with information on how to obtain EPSDT media materials.

CHF is prepared to (1) assist DHR reevaluate its current periodicity schedule and (2) assist DHR in developing an EPSDT case management and follow-up system.

V. RECOMMENDATIONS

It is extremely difficult for BSS caseworkers to (1) clearly explain the nature and value of EPSDT services, (2) assist clients in arranging appointments, and (3) assist clients in obtaining support services when these responsibilities are added onto the long list of services which BSS caseworkers are expected to provide. Because of more immediate needs, such as child abuse and protective services, EPSDT is operationally a low priority in many county BSS offices. BSS is consequently developing a proposal to hire employees who will devote 100 percent of their time to EPSDT. CHF strongly supports this effort.

Considerable planning, including a revised inter-bureau agreement, is necessary before EPSDT workers are employed and the present activities performed by BSS caseworkers are transferred. Planning should include such basic objectives as the number of children DHR hopes to screen and the rate of kept appointments it hopes to attain. (Such objectives influence the level of staffing which is appropriate.) Planning should also include the development of activities that these new EPSDT workers will perform.

Because of the potential magnitude of a revised EPSDT case management program, DHR may wish to implement an EPSDT demonstration project and assess its effectiveness and

efficiency before implementing a new system statewide. CHF recommends a demonstration project if it is feasible to perform different EPSDT procedures within the State of Kentucky.

Community Health Foundation is prepared to assist DHR in developing a revised EPSDT case management component, contingent on the availability of funding.

A revised EPSDT case management component should result in increased EPSDT utilization. This, in turn, will probably create the need for an automated tracking system that can assist EPSDT workers in their case management functions. It may also warrant the development of a data system that is capable of producing information pertinent to the evaluation of the program and capable of producing required federal reports. CHF recommends that DHR consider the development of a data system with these capabilities.

DHR should also reevaluate and revise its present annual periodicity schedule to one that is closer in line with those recommended by professional groups, such as the American Academy of Pediatrics. An annual periodicity schedule is neither required nor desirable and it would create an unnecessary demand for screening resources if the rate were to increase substantially as a result of the revised EPSDT outreach and case management component. CHF's working paper, "A Review of Recommended Periodicity Schedules," will assist DHR in reevaluating the appropriateness of its periodicity schedule.

Further, DHR should determine if its rate of reimbursement for EPSDT screenings meets the costs incurred by the providers.

APPENDIX A

TECHNICAL ASSISTANCE AGREEMENT

KENTUCKY TA AGREEMENT

Need: Define program needs in terms of functional program areas: a) outreach; b) case management; c) resources; d) eligibles; e) screening, diagnosis and treatment; f) data systems; g) program management. Indicate the level where the need exists: state, county, local.

Outreach and "no-show" demonstration project; program management.

Target Personnel: Indicate EPSDT staff or other personnel who have program responsibility. (Please do not include EPSDT targets, i.e., children, parents, etc.)

Department for Human Resources Bureau

TA Goal: Indicate the desired outcome of TA in terms of: a) information; b) product development; c) change in skill level; d) change in program.

Change in program.

I

OBJECTIVES: What are the goals of the TA efforts in relation to the defined program needs?	ACTIVITIES: List and describe a series of activities necessary to meet TA objectives. Include activities to be accomplished by both CHF and the State.
1. To obtain 75% FFP for outreach purposes.	1. Discussion with MSA Region IV to identify and clarify requirements that the State of Kentucky will need to obtain 75% FFP outreach funding. 2. CHF helps the State to evaluate the impact of changes required in order to obtain such funding.
2. Assistance to State in identification of uses of EPSDT outreach funds. (During FY 77) 3. Assistance to State to evaluate most effective use of outreach funds. Evaluation measures to be investigated: a. Decrease in no-show rate. b. Increased utilization of EPSDT (POTENTIAL TA AFTER July 1, 1977)	1. State allows several counties to serve as demonstration areas. 2. State institutes changes in policies and procedures in order for evaluation to occur 3. CHF identifies specific EPSDT workers who have responsibilities in identification, outreach and case management and who will be solely responsible for EPSDT activities. 4. CHF develops an integrated training program for outreach workers. 5. CHF develops an integrated planning framework to plan for sufficient resource requirements. 6. CHF designs a uniform case management form to be used for all EPSDT clients, regardless of eligibility criteria. 7. CHF, with assistance from regional and central MSA, makes available EPSDT client media material for health departments (posters, coloring books, etc.).

KENTUCKY TA AGREEMENT

Need: Define program needs in terms of functional program areas: a) outreach; b) case management; c) resources; d) eligibles; e) screening, diagnosis and treatment; f) data systems; g) program management. Indicate the level where the need exists: state, county, local.

Screening reimbursement rates; resource expansion.

Target Personnel: Indicate EPSDT staff or other personnel who have program responsibility. (Please do not include EPSDT targets, i.e., children, parents, etc.)

Bureau of Health Services

TA Goal: Indicate the desired outcome of TA in terms of: a) information; b) product development; c) change in skill level; d) change in program.

Change in program; information.

KENTUCKY TA AGREEMENT

Need: Define program needs in terms of functional program areas: a) outreach; b) case management; c) resources; d) eligibles; e) screening, diagnosis and treatment; f) data systems; g) program management. Indicate the level where the need exists: state, county, local.

Screening periodicity schedule.

Target Personnel: Indicate EPSDT staff or other personnel who have program responsibility. (Please do not include EPSDT targets, i.e., children, parents, etc.).

Bureau for Health Services

TA Goal: Indicate the desired outcome of TA in terms of: a) information; b) product development; c) change in skill level; d) change in program.

Information: Provide the state with periodicity schedule to provide a health care delivery program rather than merely a way to have clients use health services annually.

III

OBJECTIVES: What are the goals of the TA efforts in relation to the defined program needs?	ACTIVITIES: List and describe a series of activities necessary to meet TA objectives. Include activities to be accomplished by both CHF and the State.
Revision of periodicity schedule.	1. Clarify with Region IV that the State of Kentucky may establish other than annual periodicity schedule to follow. 2. Provide the state with a working paper discussing a more appropriate periodicity schedule to follow.

KENTUCKY TA AGREEMENT

Need: Define program needs in terms of functional program areas: a) outreach; b) case management; c) resources; d) eligibles; e) screening, diagnosis and treatment; f) data systems; g) program management. Indicate the level where the need exists: state, county, local.

Transportation tool, resources. State.

Target Personnel: Indicate EPSDT staff or other personnel who have program responsibility. (Please do not include EPSDT targets, i.e., children, parents, etc.)

BSI

TA Goal: Indicate the desired outcome of TA in terms of: a) information; b) product development; c) change in skill level; d) change in program.

Information, change in skill level.

OBJECTIVES: What are the goals of the TA efforts in relation to the defined program needs?	ACTIVITIES: List and describe a series of activities necessary to meet TA objectives. Include activities to be accomplished by both CHF and the State.
Identification of current transportation capacity, additional transportation resources required, future resource requirements and solutions to transportation problems. (POTENTIAL TA AFTER July 1, 1977)	1. CHF assists the State in evaluating current transportation policies. 2. CHF helps the state clarify regulations and insurance policies when social service workers transport clients. 3. CHF develops transportation evaluation tool. 4. CHF provides working paper discussing alternative methods such as mobile vans and volunteer transportation providers.

KENTUCKY TA AGREEMENT

Need: Define program needs in terms of functional program areas: a) outreach; b) case management; c) resources; d) eligibles; e) screening, diagnosis and treatment; f) data systems; g) program management. Indicate the level where the need exists: state, county, local.

Provider certification and monitoring; program management and evaluation.

Target Personnel: Indicate EPSDT staff or other personnel who have program responsibility. (Please do not include EPSDT targets, i.e., children, parents, etc.)

Providers

TA Goal: Indicate the desired outcome of TA in terms of: a) information; b) product development; c) change in skill level; d) change in program.

Information: Review how other states evaluate and monitor EPSDT providers.

V

OBJECTIVES: What are the goals of the TA efforts in relation to the defined program needs?	ACTIVITIES: List and describe a series of activities necessary to meet TA objectives. Include activities to be accomplished by both CHF and the State
Assist the state to develop the capacity to assess and monitor the delivery of EPSDT services. (POTENTIAL TA AFTER July 1, 1977)	Provide the State of Kentucky with a working paper that would review methods of provider certification and monitoring.

KENTUCKY TA AGREEMENT

Need: Define program needs in terms of functional program areas: a) outreach; b) case management; c) resources; d) eligibles; e) screening, diagnosis and treatment; f) data systems; g) program management. Indicate the level where the need exists: state, county, local.

Evaluation of information flow; case management.

Target Personnel: Indicate EPSDT staff or other personnel who have program responsibility. (Please do not include EPSDT targets, i.e., children, parents, etc.)

Bureau for Social Services, Bureau for Health Services, private providers, Claims Payment Personnel

TA Goal: Indicate the desired outcome of TA in terms of: a) information; b) product development; c) change in skill level; d) change in program.

Program operation.

KENTUCKY TA AGREEMENT

Need: Define program needs in terms of functional program areas: a) outreach; b) case management; c) resources; d) eligibles; e) screening, diagnosis and treatment; f) data systems; g) program management. Indicate the level where the need exists: state, county, local.

Data processing, feasibility study for an automated reporting/tracking system.

Target Personnel: Indicate EPSDT staff or other personnel who have program responsibility. (Please do not include EPSDT targets, i.e., children, parents, etc.)

State and local

TA Goal: Indicate the desired outcome of TA in terms of: a) information; b) product development; c) change in skill level; d) change in program.

Product development

VII

OBJECTIVES: What are the goals of the TA efforts in relation to the defined program needs?	ACTIVITIES: List and describe a series of activities necessary to meet TA objectives. Include activities to be accomplished by both CHF and the State.
Uniform case management reporting and tracking system. (Pending development of the federal MMIS/EPSDT module)	1. CHF meets with the following to discuss systems considerations. State Coordinator Claims Processing Personnel Case Management Data Operation Social Service Staff Health Departments Service Providers 2. State provides operational flow diagram, various record layouts, operational procedures and appropriate personnel when needed. 3. State defines role responsibilities. 4. CHF produces general systems design document.

SUMMARY OF FEDERAL FINANCIAL PARTICIPATION
REGULATIONS FOR EPSDT HEALTH
RELATED SUPPORT SERVICES

Federal Regulation

Federal financial participation at 75 percent is available for salary and other compensation, travel, and training costs of skilled professional medical personnel, and staff directly supporting such personnel, of the State title XIX agency or any other public agency, in the administration of the medical assistance program at the State and local level (45 CFR 250.120,a).

Skilled Professional Medical Personnel

The function of the "skilled professional medical" personnel position is the principal basis for determining eligibility for the 75 percent federal matching funds. The function, rather than the title, of a position is the significant factor in determining eligibility for increased matching funds. Staff classified as skilled professional medical personnel must be at a professional level of responsibility in the administration of the medical assistance program requiring medical subject area expertise.

HEW has defined "professional" and "medical" functions as follows:

Professional: the function is at a level which requires college education or equivalent and it relates directly to non-routine aspects of the program requiring the exercise of judgment.

Medical: the function is peculiar to medical programs and requires expertise in medical services care delivered, studying and evaluating the economics of medical care,

planning the program's scope, or maintaining liaison on the medical aspects of the program with providers of service and other agencies which provide health care (SRS-AT-75-50, Part B, 2, a).

These functions require knowledge and skills gained from professional training in a health science or allied scientific field. Further, the skilled professional medical personnel's functions involve overseeing the delivery of medical care and services.

Skilled professional medical personnel include:

1. physicians;
2. dentists;
3. other health practitioners;
4. nurses;
5. medical social workers;
6. psychiatric social workers;
7. health educators;
8. other specialized personnel in the field of medical care including:
   a. medical administrators,
   b. hospital or public health administrators,
   c. licensed nursing home administrators (45 CFR 250.120).

Support Staff

Support positions also qualify for increased federal matching if their activities assist the skilled professional medical staff member in carrying out the functions for which the person is responsible and which qualify for the 75 percent matching.

The critical factor for qualifying for the increased match is that the non-professional staff are responsible for performing functions directly necessary for the performance of the professional's duties (SRS-AT-76-66). There must be a direct association of the functions of the non-professional

staff with the responsibilities and functions of the skilled professional.

To establish this relationship, the skilled professional medical position must be responsible for:

1. defining the non-professional positions and functions to be performed,
2. providing for their training,
3. monitoring and evaluating their activities (SRS-AT-75-50, Part C, 7, b).

There must also be documentation that both the skilled medical professional and the supporting personnel carry out their responsibilities (SRS-AT-75-50, Part C, 7, b, p. 14). When the time of the professional and non-professional staff is split among functions that qualify for different federal matching rates, the portion of time spent on each function will determine the amount of the federal share (SRS-AT-75-50, Part B, 1, c).

A daily supervisory relationship between the skilled medical professional personnel and support is not necessary to demonstrate a "support" relationship.

> Although not necessarily responsible for immediate supervision of the support staff, the skilled professional must be ultimately responsible for the work performed by the support staff (SRS-AT-76-66).

Support Functions

The health related support functions that qualify for 75 percent match must assist in the effective utilization of the program. There are three general categories of functions that facilitate effective utilization:

1. Health education, including explaining the value

of preventive health services and periodic exams; identification and notification; case management, including referral and follow through; advocacy;

2. Program management, including arrangements for available and accessible services in existing facilities and working with professional and citizen groups to develop resources where they are not available or accessible;

3. Training and supervision of paraprofessionals to perform health related supportive service tasks (MSA-PRG-35 3/31/75, 5-70.9-00).

These three categories can be summarized as 1) client-oriented efforts usually provided at the community level; 2) provider-oriented efforts provided at the State or community level; and 3) training to perform the identified covered tasks usually provided at the community level.

Inter/Intra-agency Agreements

When support staff and/or skilled professional medical personnel for whom the increased match is being claimed are employed by a public agency other than the title XIX agency, an interagency or, in the case of separate program divisions within a larger "umbrella" agency, an intra-agency agreement would be necessary (SRS-AT-75-50, Part F).

The agreement must specifically demonstrate that the non-title XIX staff, for whom the increased match is being claimed, are directly supporting the skilled medical professional employed by the title XIX agency, or that both the professional and support staff are directly assisting the title XIX agency in the administration of the functions which qualify for the 75 percent match rate.